



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BAYLOR SURGICARE AT OAKMONT
7200 OAKMONT BLVD
FORT WORTH TX 76132

Respondent Name

TRAVELERS INDEMNITY CO

Carrier's Austin Representative Box

Box Number 05

MFDR Tracking Number

M4-12-0628-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I explained to them that each procedure performed was performed through separate sessions. Each procedure was performed in separate rooms by two different physicians and with different equipment. The block given was to control post operative pain."

Amount in Dispute: \$343.85

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier reviewed the procedures and reimbursed the Provider for the facility fees related to the rotator cuff repair and acromioplasty, but denied reimbursement for the nerve block as it was included in the reimbursement for the two primary procedures. The Provider requested reconsideration, alleging the nerve block was performed as a separate procedure in a different operating room than the rotator cuff repair and acromioplasty. The Carrier reviewed the documentation and maintained the original reimbursement determination." "In their Position Statement, the Provider contends it is entitled to two separate facility fee reimbursements...This contention is not supported by the physician's documentation...The anesthesiologist, Dr. Hughens, submitted a single anesthesiology report, which documents that both the rotator cuff repair/acromioplasty and the nerve block (the two separate procedures referenced by the Provider) were performed concurrently by Dr. Hughens, and Dr. Hughens submitted a single bill and report the anesthesiology services related to all three procedures...Consequently, based on the documentation from the anesthesiologist, the Provider is not entitled to separate facility fee reimbursement for a second room related to the nerve block injection."

Response Submitted by: Travelers, 1501 S. Mopac Expressway Suite A-320, Austin, TX 78746

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 1, 2011	ASC Services for Code 64415-SG-LT-59	\$343.85	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
Explanation of benefits dated July 26, 2011
 - Z014-97-Payment is included in the allowance for another service/procedure. This procedure is considered integral to the primary procedure billed.

Issues

1. Is CPT code 64415-SG-LT-59 a component of another procedure performed on the disputed date?
Is the requestor entitled to reimbursement?

Findings

1. The respondent denied reimbursement for CPT code 64415-SG-LT-59 based upon reason code "Z014-97-Payment is included in the allowance for another service/procedure. This procedure is considered integral to the primary procedure billed".

CPT code 64415 is defined as "Injection, anesthetic agent; brachial plexus, single".

The requestor states in the position summary that "I explained to them that each procedure performed was performed through separate sessions. Each procedure was performed in separate rooms by two different physicians and with different equipment. The block given was to control post operative pain." The requestor submitted a copy of the bill for code 64415-SG-LT-59, but not for any other service referenced in position summary.

The respondent submitted a copy of the bill from the anesthesiologist for CPT code 01630 and 64415-59.

Per NCCI edits, CPT code 64415 is a component of 01630; however, a modifier is allowed to differentiate the services. The requestor appended modifier 59 to code 64415.

Modifier -59 is defined as "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."

A review of the submitted documentation does not support a "different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual"; therefore, the requestor has not supported the use of modifier 59. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	5/24/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.